STATE OF MISSOURI
DEPARTMENT OF INSURANCE

SURPLUS LINES FILING REPORT - APPENDIX I

P.O. BOX 690
JEFFERSON CITY, MISSOURI 65102

THIS FORM DUE WITHIN 30 DAYS OF THE EFFECTIVE DATE OF COVERAGE (SUBMIT IN DUPLICATE)	RISK NUMBER
SURPLUS LINES INSURER AND % OF PARTICIPATION %	SURPLUS LINES LICENSEE
SURPLUS LINES INSURER AND % OF PARTICIPATION %	PRODUCING BROKER

1. NAME OF INSURED

ADDRESS OF INSURED

2. COMPLETE DESCRIPTION OF RISK AND ITS LOCATION

3. COMPLETE DESCRITPTION OF COVERAGE (NO ABBREVIATIONS)

4. SPECIFIC REASON FOR SURPLUS LINES PLACEMENT

5. IF MULTI-STATE RISK, ALLOCATION BASIS MUST BE ATTACHED

6. POLICY NUMBER	EFFECTIVE DATE
DATE TERMINATES	PREMIUM AMOUNT

7. IF NOT A DIRECT PLACEMENT WITH SURPLUS LINES INSURER(S), NAME AND ADDRESS OF AMERICAN BROKERAGE FIRM OR LLOYD'S CORRESPONDENT:

NAME

ADDRESS

AMENDED FILINGS ONLY

THIS PORTION TO BE USED FOR AMENDED FILINGS ONLY (FILL IN ABOVE: RISK #, SURPLUS LINES LICENSEE'S NAME, NAME AND ADDRESS OF INSURED, AND POLICY #)

THE FOLLOWING INFORMATION IS HEREBY MADE A PART OF THE ABOVE NUMBERED ORIGINAL FILING

ADDITIONAL PREMIUM	DATE EFFECTIVE
RETURN PREMIUM	DATE EFFECTIVE

ADDITIONAL INFORMATION NOT SUBMITTED ON ORIGINAL FILING

CERTIFICATION

I DO HEREBY CERTIFY TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE IS A TRUE AND ACCURATE RECORD OF SURPLUS LINES INSURANCE PROCURED PURSUANT TO CHAPTER 384, RSMo.

SURPLUS LINES LICENSEE'S SIGNATURE ▶

DIRECTOR OF INSURANCE FILED